

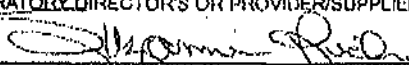
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED R 02/13/2013
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE HOUSE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 BELLEBROOK RD BRISTOL, TN 37620
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 067) SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, interview and record review, it was determined fire dampers were not maintained every 4 years. The findings include: Record review and interview with the Maintenance Director during a follow-up survey on February 13, 2013 at 10:00 a.m confirmed the facility failed to perform the 4-year required maintenance to fire dampers in the time specified in their Plan of Correction (POC). These findings were verified and acknowledged by the Maintenance Supervisor during the exit conference on February 13, 2012.</p>	(K 067)	<ol style="list-style-type: none"> 1. Heating and Air conditioning company was performing fire damper maintenance on 2/13/13. 2. All residents have the potential to be affected. All fire dampers in the building will be checked to ensure compliance with NFPA. 3. Ventilation company will perform Required maintenance on fire Dampers to ensure compliance With NFPA. 4. Results of completed maintenance will be reported to the Safety committee at the regular monthly meeting and presented to the QA&A at the regular monthly meeting. 	

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2/28/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.